OAH Docket No. 6-0900-16306-2

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HEALTH

In the Matter of the Involuntary Discharge/Transfer of M.E., Petitioner, by St. Francis Nursing Home, Respondent

FINDINGS OF FACT, CONCLUSIONS AND RECOMMENDATION

A hearing in this matter was held on December 7, 2004 in Breckenridge, Minnesota before Allan W. Klein, Administrative Law Judge. The Minnesota Department of Health ("the Department") initiated this contested case proceeding by issuing a Notice of and Order for Hearing on November 22, 2004. The notice scheduled the hearing in this matter for December 7, 2004.

Legal Services of Northwest Minnesota, 1015 – 7th Avenue North, P.O. Box 838, Moorhead, Minnesota 56561-0838, represented the Petitioner, M.E., in this proceeding. Karla Abdo, a paralegal with Legal Services of Northwest Minnesota appeared at the hearing to assist Petitioner with her appeal. Michael J. McCartney, McCartney Law Office, 216 North 5th Street, Breckenridge, Minnesota 56520, represented the Respondent, St. Francis Nursing Home ("St. Francis" or "Facility"). The hearing record closed on December 27, 2004, when the Petitioner's post-hearing submission was received.

NOTICE

This Report is a recommendation, not a final decision. The Commissioner of the Minnesota Department of Health will make the final decision after reviewing the hearing record. The Commissioner may adopt, reject or modify these Findings of Fact, Conclusions, and Recommendations. Under Minnesota Law,[1] the Commissioner may not make the final decision until after the parties have had access to this Report for at least ten days. During that time, the Commissioner must give each party adversely affected by this Report an opportunity to file objections to the report and to present argument to her. Parties should contact the Office of the Commissioner, Minnesota Department of Health, 400 Golden Rule Building, 85 East 7th Place, St. Paul, Minnesota 55101 (tel. no. 651-215-5806), to find out how to file objections or present argument.

STATEMENT OF THE ISSUE

The issue presented in this contested case proceeding is whether St. Francis may lawfully discharge the Petitioner and transfer her to another facility because the safety of individuals at St. Francis is endangered by Petitioner's conduct.

Based upon the record in this matter, the Administrative Law Judge makes the following:

FINDINGS OF FACT

1. The Petitioner, M.E., is an elderly woman who requires skilled nursing care. M.E. suffers from recurrent skin problems and has severely limited mobility. M.E. does not suffer from dementia or severe cognitive impairment. M.E. displays a modest level of functional impairment regarding cognitive matters. M.E.'s spouse (J.B.) suffers from some memory loss, due to strokes.[2] In all other respects, J.B. is capable of assisted self-care and he cares for M.E. when they are together.

2. M.E. was admitted as a resident at St. Francis on April 30, 2003, where she receives skilled nursing care. Appletree Court ("ATC") is an assisted living center adjacent to, and affiliated with St. Francis. M.E.'s husband resides in ATC. Until recent months, M.E. visited J.B. at ATC on a daily basis. While at ATC, M.E. is cared for by her spouse. M.E. is also visited at ATC by her adult daughter.

3. St. Francis has a number of residents who are cognitively impaired to varying degrees. Such residents are at risk of ingesting unattended medications. Resident rooms are accessible by other residents, although procedures are used by St. Francis to discourage residents from entering rooms other than their own. [3]

4. On October 8, 2003, M.E. and members of her family met with staff at St. Francis to discuss continued problems with M.E. taking medications that were dispensed by the nursing home. They agreed that M.E. would sign out medications to assure that the medications were dispensed. At that time, M.E. was receiving Darvocet (a narcotic analgesic) for pain. This medication was dispensed in an envelope for M.E. to carry over to ATC, where M.E. would then (hopefully) take these pills in the afternoon.[4] St. Francis staff insisted that future problems with taking medications would be resolved by requiring M.E. to take the medications as they were dispensed.[5]

5. On October 20, 2003, M.E. was dispensed two Darvocet N-100 at ATC. Staff at St. Francis were informed that M.E. misplaced the medication and M.E. thought that her daughter had removed the medication.[6] M.E.'s physician, Dr. William Mayo, concluded that M.E. no longer had the cognitive ability to self-medicate. As of October 20, 2003, Dr. Mayo ordered that St. Francis prevent M.E. from self-medicating.[7]

6. On November 8, 2003, M.E. returned from ATC and was assisted to her bedroom. While in the bedroom, staff observed three pills loose in the room. M.E.

indicated that the pills were “itch pills” (Vistaril).[8] Staff removed the pills and repeated the instruction regarding appropriate handling of medications.

7. St. Francis held a quarterly care conference for M.E. on November 13, 2003. M.E., her husband, and her adult daughter were in attendance. M.E.’s daughter told staff that she filled a weekly med-set with Advil for M.E. to take twice daily. This med-set was kept in J.B.’s apartment at ATC. M.E.’s daughter also indicated that M.E. had been given five Visaril tablets to take when needed. Staff reiterated that M.E. should only be taking medications administered by nursing staff. M.E.’s daughter expressed her understanding and agreement with the medications policy.[9]

8. On December 30, 2003, staff observed M.E. taking Aleve (a pain medication) from a locked drawer in her room. M.E. told staff that she kept the medication in her drawer since St. Francis would not let her take medications to ATC. M.E. also told staff that the nurses would not give M.E. enough medications to deal with her pain. Staff followed up by calling M.E.’s daughter, who said that she bought the medication for M.E. due to St. Francis’ restrictions on medications at ATC.[10]

9. On December 31, 2003, M.E.’s spouse came to St. Francis to take her to ATC. Staff observed that M.E. had a container with approximately 50 pills of Visteril, a container with Advil and ASA (aspirin), and an unidentified white pill. M.E. refused to allow staff to count the medications and complained that staff “treated her like a child.”[11] Staff informed M.E. that her room would be checked daily for the presence of medications. M.E. indicated that she understood the staff’s response, but she was unhappy about it.[12]

10. On January 17, 2004, staff found one tablet of aspirin in M.E’s locked drawer.[13]

11. On January 19, 2004, staff found two tablets of Vistaril in M.E’s coin purse in an unlocked drawer.[14]

12. On January 21, 2004, Social Services (of Wilkin County) was notified regarding the ongoing problem with self-administration of medications. The reasons for M.E. not having medications were explained to M.E. and Social Services indicated that M.E.’s room should be search twice daily for medications.[15] The ombudsman was notified and agreed that searching M.E.’s room was “very appropriate.”[16]

13. On January 27, 2004, staff found two tablets of Vistaril loose in M.E’s bed.[17]

14. On five separate occasions in February 2004, staff found pills in M.E’s room (once in one of M.E.’s shoes). M.E. gave varying explanations to staff as to how the pills came to be in her room and occasionally denied that the pills were hers.[18]

15. In March 2004, staff found M.E. with pills on several occasions. A local drugstore contacted to staff to advise that M.E. had called the pharmacy asking for pain mediations to be delivered to M.E.[19]

16. On March 24, 2004, St. Francis issued a "last chance" notice to M.E. M.E. was informed that her continued failure to comply with the physician's order to cease self-medication, with the resulting endangerment of herself and other residents, would result in M.E.'s transfer or discharge from St. Francis. The notice was acknowledged by the signatures of representatives of St. Francis, the ombudsman, M.E., her spouse, and her daughter.[20]

17. On May 24, 2004, staff found a packet of Colestid (a cholesterol lowering medication) in M.E.'s room. It was inside a pouch that was inside another pouch that was in a bag. The packet had M.E.'s name written on it with a marker. M.E. denied that the medication was hers.[21]

18. On June 23, 2004, staff found a M.E. holding a package of Contac Cold and Flu (an over-the-counter cold medication) with two tabs missing. M.E. acknowledged taking one dose of the medication, but she could not account for the other missing tab. M.E.'s spouse acknowledged the he brought over the medication that morning from ATC. The medication was sent back to ATC with M.E.'s spouse. M.E. and her spouse were reminded that M.E. could become ill from taking medications that the nursing staff was not aware of. St. Francis staff notified Wilkin County Social Services of the facility policy violation.[22]

19. On July 3, 2004, staff found sealed packages of Tylenol 8 hour (an over-the-counter cold medication) in M.E.'s purse. M.E. stated that she did not know that the medication was in her purse. St. Francis staff notified social services of the facility policy violation.[23]

20. On July 16, 2004, a meeting was held between St. Francis staff and administration and M.E. At that meeting, M.E.'s continuing violations of the prohibition against self-medication and presence of medications in her room were discussed. Dr. Mayo stressed the seriousness of leaving unattended medication in her room and the seriousness of M.E. continuing to self-medicate in contravention of Dr. Mayo's orders.[24] The consequence of an involuntary discharge was stressed in the event of a future violation. On August 2, 2004, David Nelson, Administrator of St. Francis, recapitulated the matters discussed at the meeting in a letter sent to M.E. Mr. Nelson stressed that the next violation would result in a discharge proceeding.[25] To help in reducing the occurrences of the problem, M.E. agreed to go over to ATC on a much less frequent basis. Her daughter went over the premises of ATC looking for medications and removing them to avoid the opportunity for bringing medications along after visits. Her daughter also asked staff at St. Francis to search M.E. upon her return from visits.[26]

21. On September 29, 2004, staff found one tab of Tylenol PM (another over-the-counter pain medication) in a drawer of a storage unit M.E.'s room. M.E. told the staffer that she "never had anything like that here."[27]

22. On October 11, 2004, Mr. Nelson provided a 30-day notice of discharge to M.E. The notice of discharge identified endangering the safety of other residents as the

reason for discharge. The notice also identified M.E.'s appeal rights.[28] The notice made no mention whatsoever of any facility that M.E. could be discharged to, in place of St. Francis.

23. By letter dated November 2, 2004, M.E. appealed the discharge notice and requested a hearing.

24. Prior to the appeal, Jerry Branson, Staff Social Worker for St. Francis, informally checked with three facilities regarding the transfer or discharge of M.E. This informal checking consisted of inquiring if any beds were open. No inquiry was made as to whether any of these facilities would accept M.E. or could accommodate J.B.'s assisted living needs. Mr. Branson stopped checking when the appeal went forward. He described what would happen if the discharge was upheld and no facility had yet agreed to accept M.E. as "not a contingency we looked at yet."[29] No facility or placement option was identified as suitable for M.E by the date of the hearing. When the appeal was filed, Branson stopped inquiring about possible placements for M.E.

25. The Notice of and Order for Hearing initiating this contested case proceeding was issued on November 22, 2004. The October 11, 2004 Notice of Discharge and the November 2, 2004 appeal letter were attached to the Notice of and Order for Hearing.

26. These Findings are based on all of the evidence in the record. Citations to portions of the record are not intended to be exclusive references.

27. The Memorandum that follows explains the reasons for these Findings, and, to that extent, the Administrative Law Judge incorporates that Memorandum into these Findings.

28. The Administrative Law Judge adopts as Findings any Conclusions that are more appropriately described as Findings.

Based upon the Findings of Fact, the Administrative Law Judge makes the following:

CONCLUSIONS

1. Both Minnesota and federal law give the Administrative Law Judge authority to conduct this proceeding and to make recommendations to the Commissioner of the Minnesota Department of Health. The law also gives the Commissioner authority to make findings, conclusions, and a final order in this proceeding.[30]

2. The Department gave the parties proper and timely notice of the hearing, and it has also complied with all of the law's substantive and procedural requirements for initiating and proceeding with this administrative contested case proceeding.

3. St. Francis is a "facility" within the meaning of 42 C.F.R. § 483.5 and is therefore subject to the requirements imposed by federal law before discharging or transferring any of its residents.[31]

4. The M.E. is a "resident" of St. Francis within the meaning of 42 C.F.R. § 483.12 and is therefore entitled to the rights created by federal law relating to any transfer or discharge by St. Francis.

5. Before discharging one of its residents, St. Francis must notify the resident and a family member or legal representative of its intent to discharge and the reasons for taking that action in writing and in a language and manner that the resident understands.[32] The notice must also include notice of the resident's right to appeal under the state process, the reason for the discharge, the effective date, the location to which the resident will be discharged, and the name, address and telephone number of the state's long term care ombudsman.[33] Federal law further requires that St. Francis to provide its residents with the written notice of discharge at least thirty days before the discharge is effective.[34] With one exception, St. Francis substantially complied with these notice requirements.

6. St. Francis failed to identify a location to which the resident will be discharged. Without conducting the necessary predischarge planning and identifying a postdischarge location for M.E., St. Francis failed to meet the notice requirements of 42 CFR § 483.12(a)(6). This defect in the notice precludes M.E. from being discharged from St. Francis,

7. Under Minnesota law, a resident appealing notification of an intended discharge must request a hearing in writing no later than 30 days after receiving written notice.[35] M.E. filed a timely appeal of the notice of discharge in this matter.

8. Under Minnesota law, St. Francis must prove facts that are required by law to support its discharge of M.E. by a preponderance of the evidence.[36]

9. Under federal law, a legal basis for discharging a resident from St. Francis is that the "health of individuals in the facility would otherwise be endangered" or that the "safety of individuals in the facility is endangered."[37] Documentation by a physician is required to establish that the health of individuals in the facility would otherwise be endangered.[38] Documentation by a physician is not required to establish that the safety of individuals in the facility is endangered.[39]

10. St. Francis has proven by a preponderance of the evidence that the M.E.'s discharge is necessary because the health of individuals in the facility would otherwise be endangered.

11. The Memorandum that follows explains the reasons for these Conclusions, and, to that extent, the Administrative Law Judge incorporates that Memorandum into these Conclusions.

12. The Administrative Law Judge adopts as Conclusions any Findings that are more appropriately described as Conclusions.

Based upon the foregoing Conclusions, the Administrative Law Judge makes the following:

RECOMMENDATION

The Administrative Law Judge recommends that the Commissioner GRANT the Petitioner's appeal and DENY the proposed discharge of M.E. from St. Francis.

Dated: January 21st, 2005

S/ Allan W. Klein
ALLAN W. KLEIN
Administrative Law Judge

Reported: Tape Recorded (two tapes); no transcript prepared.

NOTICE

Under Minnesota law,[40] the Commissioner must serve her final decision upon each party and the Administrative Law Judge by first-class mail.

MEMORANDUM

As the result of amendments to the Social Security Act contained in the Omnibus Budget Reconciliation Act of 1987,[41] a long term care facility that has been certified as a Medicare provider is allowed to discharge a resident only where certain specific circumstances are present and certain statutory due process requirements have been met. The law permits discharge of a resident when the safety of individuals in the facility is endangered. [42] The statutory discharge criteria have also been incorporated into the federal regulations that govern operation of Medicare-certified long-term care facilities, such as St. Francis.[43]

At issue in this contested case proceeding is whether St. Francis may proceed with discharging M.E. because her actions have posed a threat to the safety of other residents. The party in a contested case proceeding who is proposing that certain action be taken must prove the facts at issue by a preponderance of the evidence unless substantive law provides a different burden or standard. [44] St. Francis proposes

to discharge M.E., therefore, St. Francis bears the burden of proving by a preponderance of the evidence that it has met the legal requirements for discharge.[45]

St. Francis has successfully demonstrated that M.E. is unwilling to accept the limitations on her self-medicating. The reasons for those limits are well documented in the record of this matter. M.E. has failed to keep track of her medications for over a year. In the open setting of a nursing home, other residents have access to M.E.'s room and often the medications were left in plain sight. This conduct has required the staff to search M.E.'s room for contraband medications twice per day. Staff have also searched M.E. upon her return from trips to outside locations. Despite clear warnings, such medications were found in M.E.'s bedroom.

M.E. maintained that the last medication found, Tylenol PM, was not something that she, J.B. or her daughter was familiar with. She questioned whether that medication came from someone else. The pill was found in one of M.E.'s drawers and similar medications had been found in the same location. The preponderance of the evidence supports the conclusion that the medication was M.E.'s.

M.E. asserts that there have been no instances of other residents actually ingesting M.E.'s medications. That is not the standard for demonstrating risk. The ability for other residents to gain access to M.E.'s medications is the standard and risk has been demonstrated.[46]

Based upon all of the evidence, the Administrative Law Judge has concluded that St. Francis has established by a preponderance of the evidence that the Petitioner's discharge is necessary because the safety of individuals in the facility is endangered. St. Francis failed to engage in required predischarge planning. Only for that reason it is recommended that the Commissioner grant the Petitioner's appeal and deny St. Francis' proposal to discharge her.

The record in this matter shows that M.E., her spouse, and her adult daughter have in the past taken a casual approach to the legitimate restrictions against outside medication. This proceeding should demonstrate the seriousness of introducing outside medications into a nursing home environment. The failure of this discharge proceeding provides M.E. and her family an opportunity to commit themselves to removing the endangering condition from M.E.'s normal practices. M.E.'s conduct improved after the "last chance" warning. With this added impetus, and a demonstration of M.E.'s commitment to follow the rules, St. Francis may be able to forego reissuing the notice of discharge. Perhaps St. Francis could enter into a written agreement with M.E. whereby she would waive her right to another hearing in exchange for the Facility agreeing to not discharge M.E. unless she violated the rules again. But any such agreement must be voluntary on the parts of both M.E. and the Facility. The Administrative Law Judge cannot impose it upon either of them.

A.W.K.

[1] Minn. Stat. § 14.61 (2004). (Unless otherwise specified, all references to Minnesota Statutes are to the 2004 edition.)
[2] Testimony of J.B.
[3] Testimony of Jerry Branson.
[4] Testimony of M.L. (M.E.'s daughter).
[5] Ex. 1, Resident Chart, 10/20/03 normal note.
[6] *Id*.
[7] Testimony of Susan Heitkamp; Ex. 1, Resident Chart, 10/20/03 treatment note.
[8] Ex. 1, Resident Chart, 11/8/03 medication note.
[9] Ex. 2, Resident Chart, 11/13/03 care conference note.
[10] Ex. 1, Resident Chart, 12/30/03 normal note.
[11] Ex. 1, Resident Chart, 12/31/03 medication note.
[12] *Id*.
[13] Ex. 1, Resident Chart, 1/17/04 normal note.
[14] Ex. 1, Resident Chart, 1/19/04 normal note.
[15] Ex. 1, Resident Chart, 1/21/04 normal note.
[16] Ex. 1, Resident Chart, 1/28/04 normal note.
[17] Ex. 1, Resident Chart, 1/27/04 normal note.
[18] Ex. 1, Resident Chart, normal notes from February 9, 11, 16, 26 and 29.
[19] Ex. 1, Resident Chart, 3/19/04 normal.
[20] Ex. 1, 3/24/04 agreement.
[21] Ex. 1, Variance Report, May 24, 2004.
[22] Ex. 1, Variance Report, June 29, 2004; Ex. 1, Resident Chart, 6/23/04 normal note.
[23] Ex. 1, Variance Report, July 3, 2004; Ex. 1, Resident Chart, 7/3/04 normal note.
[24] Testimony of Branson.
[25] Ex. 1, Nelson Letter, August 2, 2004.
[26] Testimony of M.L.
[27] Ex. 1, Variance Report, September 29, 2004.
[28] Ex. 1, Nelson Letter, October 11, 2004.
[29] Testimony of Branson.
[30] *See* Minn. Stat. §§ 14.50 and 144A.135, as well as sections 1819(e)(3) and 1919(e)(3) of the Social Security Act, codified in 42 U.S.C. §§ 1395-3(e) and 1396r(e).
[31] *See generally* 42 C.F.R. § 483.12.
[32] 42 C.F.R. § 483.12(a)(4).
[33] 42 C.F.R. § 483.12 (a) 6).
[34] 42 C.F.R. § 483.12 (a)(5).
[35] Minn. Stat. § 144A.135(b).
[36] Minn. R. pt. 1400.7300, subp. 5; *In the Matter of the Involuntary Discharge or Transfer of J.S. by Ebeneezer Hall*, 512 N.W.2d 604,610 (Minn. App. 1994).
[37] 42 C.F.R. § 483.12(a)(2)(iii) and (iv).
[38] 42 C.F.R. § 483.12(a)(3)(ii).
[39] 42 C.F.R. § 483.12(a)(3).
[40] Minn. Stat. § 14.62, subd. 1.
[41] Section 1919(c) of the Social Security Act Amendments of 1987, Public Law 100-203, codified at 42 U.S.C. § 1396r(c)(2).
[42] 42 U.S.C. § 1396r(c)(2)(iii).
[43] 42 C.F.R. § 483.12. The regulations are almost identical to the statute. Further references in this Memorandum are to the requirements as set forth in 42 C.F.R. § 483.12.
[44] Minn. R. 1400.7300, subp. 5.
[45] In *Ebeneezer Hall*, *supra*, 512 N.W.2d at 610, the Minnesota Court of Appeals confirmed that "a nursing facility proposing to transfer or discharge a resident must prove the supporting facts by a preponderance of the evidence."

[46] In fact, the potential exists for citing the facility under the survey process, if effective measures are not taken to prevent access by other residents to unattended, unauthorized medications. Testimony of Branson.